5101:3-3-26 Cost Reports

iection was raised in paragraph (A)(1) that specifying February 28th as the due date of annual cost reports is not in conformity with state . ORC 5111.26(A)(2) states cost reports are to be filed "within sixty days." Since there are 59 days in January and February, the rule is onsistent with state law—i.e., 59 days are within 60 days.

bjections were raised that 60 days are too short a time period for most providers or accountants. However, the 60-day period is a matter of state law. It was further argued that the 30-day extension period should be routinely granted. The department has no objection to granting extension to all homes except those selected for the audit to determine the predetermined G & A rate. The department needs the four months prior to July 1, 1980 to audit the homes selected in the sample for the G & A rate.

Objection was raised regarding the 30-day period in paragraph (A)(2) for quarterly cost reports. The department is revising the time period to 60 days. Objection was also raised regarding the filing of the quarterly cost report. However, the department is not revising this rule because quarterly reports are required for the department to fulfill its statutory obligation to revise the nursing and habilitation rate if it is substantially excessive.

Objection was raised regarding the loss of the efficiency incentive during the 30-day extension period. The department agrees and has clarified its provisions that the reduction in the rate is applied as required by ORC 5111.26(A)(2) but that the efficiency incentive is restored at the time of settlement during any extension granted by the department.

Objection was raised regarding the negative actions resulting for failure to provide financial, statistical, or medical records was not based in statute. The department agrees to eliminate paragraph (G)(3) regarding failure to cooperate. The department is retaining paragraphs (G)(1), (G)(2), and (G)(4), and notes these are current provisions which are merely being recodified, and notes that all suspensions are subject to a Chapter 119 hearing before they are imposed.

5101:3-3-27 Audit

Objection was raised regarding paragraph (A) which states that interim settlements will be made for some cost items within five months as opposed to 12 specified by state law. Since the department is being more responsive than the law provides, it is difficult to understand the objection. However, the department will add another paragraph specifying that items previously not settled will be settled within 12 months from the date the cost report is filed.

5101:3-3-28 Ownership Changes

Numerous objections were raised regarding the rules in paragraphs (A), (B), and (C). These were drafted in light of present federal regulations which had created an impossible situation whenever there was an ownership change. A new owner regardless of the date of sale could not be recognized until he obtained a new provider agreement which could not be earlier than the date the health department certified compliance (which sometimes took months).

ever, federal regulations were published after these rules were committed to print which solved the problem (and the objections to the osed rules). The federal regulations defined change of ownership and specified the effect of ownership change upon the provider greement. Essentially the new federal regulation provides for the assignment of the old provider agreement (with its preexisting provisions) the new owner.

Objection was raised to the provision which would obviate the need of holding two months Medicaid payments in escrow. There is no reason to withhold two months payments when the buyer is purchasing both assets and liabilities.

Objection was raised to the department's placing the funds in escrow. ORC 5111.25(B) states that the funds shall be placed in escrow, but does not say who. It is logical that the agency possessing the checks would place the funds in escrow.

Objection was raised that paragraph (G)(2) would permit the department to go beyond the 60 days before finalizing an audit. The department agrees that the rule needs revision, and has added that the 60-day period may be exceeded only if the provider fails to supply information needed for an audit, and that the extension would only be for 14 days after the provider supplied the needed information.

Objection was raised regarding the department's proposal in paragraph (H)(1) to collect overpayments from the money in the escrow account. The argument was that only excess depreciation could be recaptured not overpayments for other reasons. The department disagrees with this interpretation. ORC 5111.25(D) states the department shall "... report its findings and the amount of ***any*** money owed to the department by the home ... (and) the funds held in escrow ***less*** any amounts due to the department..." (empnasis added). In addition, it does not seem logical to identify an overpayment, release the funds and then try to recollect.

Objection was raised regarding paragraph (I) which states that the interest earned should reduce the size of the overpayment. ORC 5111.25(D) states the funds held in escrow (which includes interest) shall be used to reduce the overpayment.

Objection was raised that the department did not include the proration of depreciation between Medicaid and non-Medicaid, as specified in state law [paragraph (K)]. This comment shows a lack of familiarity with basic accounting principles. The proration has already occurred by application of paragraph (K)(2) which breaks down the depreciation to the "amount actually paid by the department."

5101:3-3-30 Behavioral/Mental

Comment was made that not enough time was allocated for social service programs. The department initially computed the allowance on the basis of the Nursing Home Commission's recommendation of one social worker/activities worker per 60 residents. The department is revising paragraph (E) to double the allocation—e.g., one social worker activities worker per 30 residents

The department is revising paragraph (C)(4) deleting the last sentence requiring periodic psychiatric evaluations.

5101:3-3-33 Mobility

perationalizing of the patient assessment program revealed potential defects in the weighing factors used in order to prevent increas- pendency upon institutional services.

st, the weighing value assigned created too great a value for patients who were totally dependent as opposed to patients who required ensive services. The end result was that institutions could find it more profitable not to provide services. The discrepancy was corrected by reducing the additional time value in paragraph (D)(3) through the elimination of the administrative/supervisory overhead component, and by increasing the additional time value in paragraph (D)(2) through the increase in the restorative care component.

Second, the additional time allocated for patients requiring limited assistance in paragraph (D)(1) was insufficient to recognize the practic used by many facilities of employing a nurse's aide (trained in physical therapy) to provide routine maintenance services aimed for the p vention of contractures. An additional 16 minutes per patient day was added.

5101:3-3-37 Dressings
The description of the service unit was expanded to include preventive skin care.

5101:3-3-38 Incontinence/Catheters
The operationalizing of the patient assessment system revealed that very little catherization was being done (7% of the population receiving the service more than 15 times a month and 1% less than 15 times a month) while over 19% of the population was incontinent and either (1) receiving care in advance of need or (2) were not receiving care in advance of need. It thus became apparent that a more equitable system would be to combine services currently in paragraphs (C)(2) and (C)(3) into one paragraph [(C)(2)] and divide services currently in paragraph (C)(4) into (C)(3) for those not receiving services in advance of need and (C)(4) for those who were receiving services in advance of need. The time value of the new paragraph (C)(2) was the previous (C)(3); the time value for the new (C)(3) was the mean time of the previous (C)(4), and the time value for (C)(4) remained the same. This recognizes the greater time necessary for the services represented by providing services in advance of need.

5101:3-3-39 Enema or Douches
A new category was added for rectal stimulation.

5101:3-3-44 Habilitation
One individual commented about the title of the section (Habilitation). The department used this term because it is the term used in the statute. However, there is no doubt that services were intended for gereatric patients as is evident by the department's rule in paragraph (A)(3).

Several individuals commented regarding the specifics of the habilitation/rehabilitation standard. Some of the comments were based upon the presentation of the patient assessment system at the seminars conducted throughout the state in February. At that time, it was evident that the written material did not adequately convey the basic purpose of this standard. Such corrections were incorporated into the rules for this standard. These were the different time frames for ICF-MRs, the clarification of what constitutes interdisciplinary team's plan of care when only one service is provided, and the interrelationship of restorative care services present in the first 14 standards (rules 5101:3-3-30 to 5101:3-3-43) and the rehabilitation/habilitation substandards 15-1 through 15-5 (rules 5101:3-3-45 to 5101:3-3-49).

Concerns were expressed regarding the department's prior approval requirement for the continuation of specialized rehabilitation/habilitation services if the patient's functional level has not shown improvement for a period of 60 days (or 90 days in case of ICF-MRs). It was asserted that a significant number of patients (particularly residents in ICF-MRs) require considerable time before improvement is not

It is important to note that the department is not requiring complete rehabilitation of the patient within a specific time period, only that sc improvement is achieved as a result of the provision of the specialized services. It is also important to note that there is a restorative component within the routine service standard. Finally, the improvement is measured against an instrument which measures functional improvement, which in the case of ICF-MR is a very detailed instrument known as BCP. The prior authorization requirement is a protection against abuse—i.e., provision of services for the sake of providing services regardless of the benefits being provided the recipient.

Federal regulations found at 42 CFR 456.1(b)(1) and other places require that the department adopt "methods and procedures to safeguard against unnecessary utilization of care and services." The department's requirement for prior approval for the continuation of specialized services, when these services have not improved a patient's condition after 60 days is the department's method and procedure to safeguard against the unnecessary utilization of care and service. The department does agree that 90 days may be too short a time frame in an ICF-MR during the initial implementation phase and will lengthen the period to 180 days.

Finally, it was suggested that the amount of time for planning activity for patients not in a habilitation/rehabilitation plan be increased. The department concurs. However, the comment regarding that time for evaluation was insufficient in an ICF-MR facility ignores the fact that reevaluations are done on a quarterly basis whereas the allocation is on a per month basis.

5101:3-3-45 Specialized Services
The particular substandard was designed to recognize services of professional staff who are not licensed therapists in carrying out an individual rehabilitative/habilitative plan. Some concerns were expressed that the language should be clarified to more adequately convey the intent, and particularly to recognize the staff under the supervision of a QMRP in an ICF-MR. The department agrees, and has made the corresponding changes.

5101:3-3-49 Psychosocial Services
Testimony was provided that psychologists can authorize the same range of services as a psychiatrist, and that consequently approval of use of special personnel should be extended to psychologists. The department agrees and has made the corresponding revisions.

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5101:3-1-48 Abbreviations.

The following are abbreviations used in rules under designation 5101:3 of the Administrative Code.

(A) CWD—county welfare department

(B) DD—developmental disability

(C) DHEW—department of health, education, and welfare

(D) DPW—department of public welfare

(E) EPSDT—early and periodic, screening, diagnosis and treatment

(F) FICA—Federal Insurance Contribution Act

(G) GR—general relief

(H) HHS—department of health and human services (formerly department of health, education, and welfare, name change effective May 5, 1980)

(I) HIM—health insurance manual

(J) ICF—intermediate care facility

(K) ICF-MR—intermediate care facility for the mentally retarded

(L) IHP—individual habilitation plan

(M) LPN—licensed practical nurse

(N) LTCF—long-term care facility

(O) MR—mentally retarded

(P) MR/IPR—medical review/independent professional review

(Q) ODH—Ohio department of health

(R) ODPW—Ohio department of public welfare

(S) PSRO—professional standards review organization

(T) QMRP—qualified mental retardation professional

(U) RN—registered nurse

(V) SNF—skilled nursing facility

(W) SNF/ICF—skilled nursing facility/intermediate care facility

(X) S/UR—surveillance/utilization review

(Y) Title XVIII—medicare

(Z) Title XIX—medicaid

(AA) Title XX—social services

(BB) UR—utilization review

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5101:3-1-49 DEFINITIONS.

FOR THE PURPOSE OF RULES IN CHAPTERS 5101:3-1 AND 5101:3-3 OF THE ADMINISTRATIVE CODE, THE FOLLOWING DEFINITIONS SHALL APPLY.

(A) "AUDIOLOGIST" IS A PERSON WHO IS LICENSED AND REGISTERED BY THE STATE AS AN AUDIOLOGIST.

(B) "CERTIFIED BED" MEANS ANY BED WITHIN THE MAXIMUM NUMBER OF BEDS APPROVED BY THE ODH ACCORDING TO CONDITIONS OF PARTICIPATION FOR EITHER MEDICARE OR MEDICAID IN AN LTCF WHICH IS PROVIDING SERVICES AS AN SNF, ICF, SNF/ICF OR ICF-MR. THIS INCLUDES A BED IN A SINGLE-BED ROOM IF THE CERTIFICATION REQUIREMENTS ARE MET.

(C) "CHANGE OF OWNERSHIP" IS DEFINED AS ONE OF THE FOLLOWING TRANSACTIONS BETWEEN UNRELATED PARTIES:

(1) IN THE CASE OF A PARTNERSHIP, THE REMOVAL, ADDITION, OR SUBSTITUTION OF A PARTNER.

(2) IN THE CASE OF A PROPRIETORSHIP, THE TRANSFER OF TITLE AND PROPERTY TO ANOTHER PARTY.

(3) IN THE CASE OF A CORPORATION, THE MERGER OF THE PROVIDER CORPORATION INTO ANOTHER CORPORATION OR THE CONSOLIDATION OF TWO OR MORE CORPORATIONS, EITHER OF WHICH ACTION RESULTS IN THE CREATION OF A NEW CORPORATION. TRANSFER OF CORPORATE STOCK OR THE MERGER OF ANOTHER CORPORATION INTO THE PROVIDER CORPORATION DOES NOT CONSTITUTE A CHANGE OF OWNERSHIP.

(4) IN THE CASE OF LEASING, THE LEASE OF ALL OR PART OF A PROVIDER FACILITY CONSTITUTES A CHANGE OF OWNERSHIP OF THE LEASED PORTION.

(D) "COMMON OWNERSHIP" MEANS THAT AN INDIVIDUAL OR INDIVIDUALS POSSESS OWNERSHIP OR EQUITY AMOUNTING TO FIVE PER CENT OR MORE IN AN ORGANIZATION.

(E) "CONTINUING CARE" (ALSO KNOWN AS "LIFE CARE") REFERS TO THE LIVING SETTING WHICH PROVIDES THE RESIDENT WITH AN APARTMENT ROOM OR LODGING, MEALS, MAINTENANCE SERVICES, AND, WHEN NECESSARY, NURSING HOME CARE. ALL SERVICES ARE PROVIDED ON THE PREMISES OF THE CONTINUING CARE COMMUNITY. THE RESIDENT SIGNS A CONTRACT WHICH IDENTIFIES THE CONTINUUM OF SERVICES TO BE COVERED BY THE RESIDENT'S INITIAL ENTRANCE FEE AND SUBSEQUENT MONTHLY CHARGES. IF A CONTINUING CARE CONTRACT PROVIDES FOR A LIVING ARRANGEMENT WHICH INCLUDES HEALTH CARE SERVICES, MEDICAID PAYMENT CANNOT BE MADE FOR THOSE SERVICES COVERED BY THE CONTRACT.

(F) "CONTROL" MEANS THAT AN INDIVIDUAL OR AN ORGANIZATION HAS THE POWER, DIRECTLY OR INDIRECTLY, TO SIGNIFICANTLY INFLUENCE OR DIRECT THE ACTIONS OR POLICIES OF ANOTHER ORGANIZATION.

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(G) "CONVICTED" MEANS THAT A JUDGMENT OF CONVICTION HAS BEEN ENTERED BY A FEDERAL, STATE, OR LOCAL COURT, REGARDLESS OF WHETHER AN APPEAL FROM THAT JUDGMENT IS PENDING.

(H) "DURABLE MEDICAL EQUIPMENT" IS EQUIPMENT WHICH CAN STAND REPEATED USE, IS PRIMARILY AND CUSTOMARILY USED TO SERVE A MEDICAL PURPOSE, AND IS GENERALLY NOT USEFUL TO A PERSON IN THE ABSENCE OF AN ILLNESS OR INJURY.

(I) "EFFECTIVE DATE OF HEALTH CARE" IS THE FIRST DAY OF THE FIRST MONTH DURING WHICH THE APPLICANT MET THE ELIGIBILITY CRITERIA FOR THE MEDICAID PROGRAM. A PERSON ELIGIBLE IN THE FIRST MONTH PRIOR TO APPLICATION (BUT NOT THE SECOND OR THIRD MONTH) HAS RETROACTIVE COVERAGE FOR ONE MONTH. A PERSON ELIGIBLE IN THE SECOND MONTH PRIOR TO APPLICATION (BUT NOT IN THE FIRST OR THIRD MONTH) HAS RETROACTIVE COVERAGE FOR TWO MONTHS PRIOR TO APPLICATION. IF NO RETROACTIVE ELIGIBILITY EXISTS, THE EFFECTIVE DATE OF HEALTH CARE IS THE FIRST DAY OF THE MONTH OF APPLICATION.

(J) "EFFECIENCY INCENTIVE" IS A SPECIAL ALLOWANCE IN REIMBURSEMENT TO AN LTCF TO ENCOURAGE THE MAINTENANCE OF COSTS BELOW ALLOWABLE CEILINGS IN THE COST CENTERS FOR ADMINISTRATION AND GENERAL SUPPORT SERVICES AND FOR PROPERTY AND OWNERSHIP COSTS.

(K) "HOME OFFICE COST" MEANS THE ADMINISTRATIVE OVERHEAD, SUPPORT SERVICES, AND OTHER INDIRECT EXPENSES PROVIDED AT A SITE OTHER THAN THE LTCF TO PERSONNEL DISCHARGING FUNCTIONS NECESSARY FOR THE EFFICIENT AND EFFECTIVE OPERATION OF THE LTCF. HOME OFFICE COST DOES INCLUDE ALLOWABLE COST OF ACCOUNTANTS, LEGAL PERSONNEL, DATA PROCESSING, ETC., SERVING MORE THAN ONE FACILITY.

(L) "INDIRECT OWNERSHIP INTEREST" IS OWNERSHIP INTEREST IN AN ENTITY WHICH HAS A DIRECT OR INDIRECT OWNERSHIP INTEREST IN THE LTCF.

(M) "LICENSED BED" MEANS ANY BED WITHIN THE MAXIMUM BED CAPACITY OF A HOME AS AUTHORIZED BY ODH IN ACCORDANCE WITH CHAPTER 3721. OF THE REVISED CODE, OR AS AUTHORIZED BY THE DEPARTMENT OF MENTAL HEALTH OR ODMR/DD IN ACCORDANCE WITH SECTION 5123.18 OF THE REVISED CODE.

(N) "LONG-TERM CARE FACILITY" (LTCF) IS AN INSTITUTION LICENSED BY THE APPROPRIATE HEALTH STANDARD SETTING AGENCY TO PROVIDE SKILLED NURSING SERVICES, INTERMEDIATE NURSING SERVICES, OR INTERMEDIATE CARE SERVICES FOR THE MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED.

(O) "MANAGEMENT FEE" IS A PAYMENT TO AN INDIVIDUAL, AGENCY, OR ORGANIZATION TO WHICH AN LTCF HAS CONTRACTED OR DELEGATED ANY OR ALL OF ITS MANAGEMENT FUNCTIONS ORDINARILY CONSIDERED PART OF THE DUTIES OF A LICENSED ADMINISTRATOR OR ASSISTANT ADMINISTRATOR.

(P) "MANAGING EMPLOYEE" IS A GENERAL MANAGER, BUSINESS MANAGER, ADMINISTRATOR, DIRECTOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROLS, OR WHO DIRECTLY OR INDIRECTLY CONDUCTS THE DAY-TO-DAY OPERATION.

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(Q) "NONRESIDENT PATIENT OR RECIPIENT" IS A SHORT-TERM RESIDENT OF AN LTCF WHO USES THE LTCF FOR RESPITE SERVICES OR OTHER SHORT-TERM SERVICES, FOR EXAMPLE, ONLY DURING SCHOOL BREAKS, TRIAL VISITS, OR VACATIONS. A NONRESIDENT RECIPIENT IS NOT ELIGIBLE FOR PAID LEAVE DAYS UNDER RULE 5101:3-3-03 OF THE ADMINISTRATIVE CODE.

(R) "OCCUPATIONAL THERAPY" INCLUDES ASSISTANCE TO THE PHYSICIAN IN EVALUATING THE PATIENT'S LEVEL OF FUNCTION BY APPLYING DIAGNOSTIC AND PROGNOSTIC TESTS AND GUIDING THE PATIENT IN HIS USE OF THERAPEUTIC, CREATIVE, AND SELF-CARE ACTIVITIES FOR IMPROVING FUNCTION. OCCUPATIONAL THERAPY INCLUDES TEACHING MANUAL SKILLS AND INDEPENDENCE IN PERSONAL CARE TO STIMULATE MENTAL AND PHYSICAL ACTIVITY OF THE PATIENT AND OTHER ACTIVITIES AS DEFINED IN SECTION 4755.01 OF THE REVISED CODE. SERVICES MUST BE PROVIDED BY A QUALIFIED OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT.

(S) "OCCUPATIONAL THERAPIST" IS A PERSON WHO IS LICENSED BY THE STATE AS AN OCCUPATIONAL THERAPIST.

(T) "OCCUPATIONAL THERAPY ASSISTANT" IS A PERSON WHO IS LICENSED AND REGISTERED BY THE STATE AS AN OCCUPATIONAL THERAPY ASSISTANT.

(U) "OWNERSHIP INTEREST" IS THE POSSESSION OF EQUITY IN CAPITAL, STOCK, OR PROFITS.

(V) "PHYSICAL THERAPY" MEANS THE EVALUATION AND TREATMENT OF A PERSON BY PHYSICAL MEASURES AND THE USE OF THERAPEUTIC EXERCISES AND REHABILITATIVE PROCEDURES, WITH OR WITHOUT ASSISTIVE DEVICES, FOR THE PURPOSE OF PREVENTING, CORRECTING, OR ALLEVIATING ANY DISABILITY. PHYSICAL THERAPY INCLUDES THE ESTABLISHMENT AND MODIFICATION OF PHYSICAL THERAPY PROGRAMS, TREATMENT PLANNING, INSTRUCTION, AND CONSULTATIVE SERVICES. PHYSICAL MEASURES INCLUDE MASSAGE, HEAT, COLD, AIR, LIGHT, WATER, ELECTRICITY, SOUND, AND THE PERFORMANCE OF TESTS OF NEUROMUSCULAR FUNCTION AS AN AID TO SUCH TREATMENT. PHYSICAL THERAPY DOES NOT INCLUDE THE DIAGNOSIS OF A PATIENT'S DISABILITY, THE USE OF ROENTGEN RAYS OR RADIUM FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES, OR THE USE OF ELECTRICITY FOR CAUTERIZATION OR OTHER SURGICAL PURPOSES. PHYSICAL THERAPY INCLUDES PHYSIOTHERAPY.

(W) "PHYSICAL THERAPIST" IS A PERSON WHO IS LICENSED BY THE STATE AS A PHYSICAL THERAPIST.

(X) "PHYSICAL THERAPIST ASSISTANT" IS A PERSON WHO IS LICENSED BY THE STATE AS A PHYSICAL THERAPY ASSISTANT AND WHO IS A GRADUATE OF A TWO-YEAR PROGRAM WHICH IS APPROVED BY THE "AMERICAN PHYSICAL THERAPY ASSOCIATION."

(Y) "PUBLIC FACILITY" IS ANY FACILITY OWNED BY A FEDERAL, STATE, COUNTY, CITY, OR OTHER LOCAL GOVERNMENT AGENCY OR INSTRUMENTALITY. THIS DEFINITION INCLUDES FACILITIES OWNED JOINTLY BY TWO OR MORE GOVERNMENT ENTITIES BUT DOES NOT INCLUDE FACILITIES OWNED JOINTLY BY GOVERNMENT AND PRIVATE ORGANIZATIONS.

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(Z) "QUALIFIED MENTAL RETARDATION PROFESSIONAL" MEANS A PERSON WHO HAS SPECIALIZED TRAINING OR ONE YEAR OF EXPERIENCE IN TREATING OR WORKING WITH THE MENTALLY RETARDED AND IS ONE OF THE FOLLOWING:

(1) A PSYCHOLOGIST WITH A MASTER'S DEGREE FROM AN ACCREDITED PROGRAM.

(2) A LICENSED DOCTOR OF MEDICINE OR OSTEOPATHY.

(3) AN EDUCATOR WITH A DEGREE IN EDUCATION FROM AN ACCREDITED PROGRAM.

(4) A SOCIAL WORKER WITH A BACHELOR'S DEGREE IN:

(a) SOCIAL WORK FROM AN ACCREDITED PROGRAM; OR

(b) A FIELD OTHER THAN SOCIAL WORK AND AT LEAST THREE YEARS OF SOCIAL WORK EXPERIENCE UNDER THE SUPERVISION OF A QUALIFIED SOCIAL WORKER.

(5) A PHYSICAL THERAPIST OR OCCUPATIONAL THERAPIST.

(6) A SPEECH PATHOLOGIST OR AUDIOLOGIST.

(7) A REGISTERED NURSE.

(8) A THERAPEUTIC RECREATION SPECIALIST WHO IS A GRADUATE OF AN ACCREDITED PROGRAM.

(AA) "RATE YEAR" IS THE PERIOD OF TIME DURING WHICH THE CALCULATED PER DIEM IS PAID. THE RATE YEAR BEGINS WITH THE AUGUST PAYMENT FOR SERVICES RENDERED BEGINNING JULY ONE AND ENDS WITH THE JULY PAYMENT OF THE FOLLOWING YEAR FOR SERVICES RENDERED THROUGH JUNE THIRTIETH.

(BB) "RECIPIENT" IS A PERSON, INDIVIDUAL, RESIDENT, OR PATIENT ELIGIBLE TO RECEIVE COVERED SERVICES UNDER THE MEDICAID PROGRAM.

(CC) "RELATED PARTY" MEANS ONE INDIVIDUAL OR ORGANIZATION IS, TO A SIGNIFICANT EXTENT, ASSOCIATED OR AFFILIATED WITH, OWNS OR IS OWNED BY, OR HAS CONTROL OF OR IS CONTROLLED BY THE ORGANIZATION OR INDIVIDUAL FURNISHING THE GOODS OR SERVICES, FACILITIES, OR SUPPLIES.

(DD) "SCIENTIFICALLY SELECTED RANDOM SAMPLE" IS THE NUMBER OF INDIVIDUAL LTCFs RANDOMLY SELECTED OUT OF ALL PARTICIPATING NURSING HOMES TO ACHIEVE A NINETY-FIVE PER CENT PROBABILITY OF .10 PROPORTIONAL CLOSENESS TO ACTUAL VALUE IN ALL LTCFs.

(EE) "SOCIAL WORKER AS A QUALIFIED CONSULTANT" IS A PERSON WHO IS A GRADUATE OF A SCHOOL OF SOCIAL WORK ACCREDITED OR APPROVED BY THE "COUNCIL ON SOCIAL WORK EDUCATION," AND HAS ONE YEAR OF SOCIAL WORK EXPERIENCE IN A HEALTH CARE SETTING.

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(FF) "SPEECH PATHOLOGY AND AUDIOLOGY" INCLUDES ASSISTANCE TO THE PHYSICIAN IN EVALUATING THE COMMUNICATION SKILLS OF THE PATIENT FOR PURPOSES OF INITIATING APPROPRIATE CORRECTIVE THERAPY. SERVICES MUST BE PROVIDED BY A QUALIFIED SPEECH PATHOLOGIST OR AUDIOLOGIST.

(GG) "SPEECH PATHOLOGIST" IS A PERSON WHO IS LICENSED AND REGISTERED BY THE STATE AS A SPEECH PATHOLOGIST.

(HH) "SUBCONTRACTOR" MEANS ANY ENTITY, INCLUDING AN INDIVIDUAL OR INDIVIDUALS, THAT CONTRACTS WITH A PROVIDER TO SUPPLY A SERVICE, EITHER TO THE PROVIDER OR DIRECTLY TO A RECIPIENT FOR WHICH MEDICAID REIMBURSES THE PROVIDER THE COST OF THE SERVICE.

(II) "SUPPLIER" IS AN INDIVIDUAL, AGENCY, OR ORGANIZATION FROM WHICH AN LTCF PURCHASES GOODS AND SERVICES USED IN CARRYING OUT ITS RESPONSIBILITIES UNDER MEDICAID.

(JJ) "UNRELATED PARTY" IS THE LACK OF FAMILY RELATIONSHIP BETWEEN ANY BUYER AND SELLER OF A FACILITY FOR A PERIOD OF AT LEAST TWO YEARS PRIOR TO THE TRANSACTION IN QUESTION, OR THE LACK OF COMMON OWNERSHIP/CONTROL.

(KK) "WHOLLY OWNED SUPPLIER" IS A SUPPLIER WHOSE TOTAL OWNERSHIP INTEREST IS HELD BY AN LTCF OR BY A PERSON, PERSONS, OR OTHER ENTITY WITH AN OWNERSHIP OR CONTROLLING INTEREST IN AN LTCF.

EFFECTIVE DATE:_____

REPLACES RULE 5101:3-1-49

CERTIFICATION:_____

_____
DATE

PROMULGATED UNDER RC CHAPTER 119.

RULE AMPLIFIES RC SECTION 5111.02

PRIOR EFFECTIVE DATE 7/1/80

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5101:3-1-57 Appeals process for providers from proposed departmental actions.

(A) The appeals process is designed to provide a hearing under Chapter 119. of the Revised Code (Administrative Procedures Act) whereby a provider may appeal the proposed decision of the department to suspend, deny, terminate or not renew a provider agreement, or to implement a final fiscal audit.

(1) The appeals process does not apply in the following circumstances:

(a) Whenever the terms of a provider agreement require the provider to have a license, permit or certificate issued by an official, board, commission, department, division or bureau, or other agency of state government other than the ODPW, and the license, permit or certificate has been denied or revoked.

(b) Whenever providers who participate in the medicare program where the negative action taken by the department of health and human services is binding on the provider's medicaid participation and where the federal agency provides an opportunity for a hearing.

(2) If a provider objects to a proposed adjudication order of the department which would result in the denial, termination, suspension or nonrenewal of a provider agreement or if he wishes to contest a final fiscal audit, the provider may request a formal hearing which shall be governed by Chapter 119. of the Revised Code, as amended. Such requests must be submitted in writing to the director, ODPW.

(3) Continuation of payment during the appeal of the proposed termination or nonrenewal of a provider agreement will occur as follows:

(a) Payment under regulations for covered services provided to eligible recipients will continue during the administrative appeals process.

(b) In the case of skilled nursing and intermediate care facilities, payment will continue during the administrative appeals process for those recipients admitted to the facility prior to the determination of noncertification or provider agreement termination. No new admissions will be authorized subsequent to the effective date of the department's termination action or the effective date of noncertification by the ODH.

(B) Other administrative actions affecting the provider's medicaid program status (such as rate calculations for long-term care facilities) which are not subject to hearings under Chapter 119. of the Revised Code may be reconsidered by the appropriate division chief upon written request by the affected provider to the director, ODPW.

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